TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TOMBALL CHIROPRACTIC SPINE AND REHAB CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-3650-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bills for each date of service were timely submitted for payment to AIG and were supported by all required documentation. AIG never responded to the claims even though they remained 'pending' in their system for several months…The services which required preauthorization were properly pre-authorized by Health Direct, Inc. and a copy of the approved preauthorization was sent with the claims which required preauthorization."

Amount in Dispute: $1,840.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2016	CPT Codes A4556, 72100, 99203-25, 97140-59-GP, G0283-GP, 97110-GP, and 97010-59-GP	$360.00	$311.96
March 30, 2016 March 31, 2016 April 4, 2016 April 5, 2016	CPT Codes 99211-25, 97140-59-GP, G0283-GP, 97110-GP (X1) and 97010-59-GP	$190.00/each date	$137.95 X 4 = $551.80
April 6, 2016	CPT Codes 99213-25, 97140-59-GP, G0283-GP, 97110-GP (X2) and 97010-59-GP	$190.00	$190.00
April 15, 2016	CPT Code 99213-25	$190.00	$100.00
April 25, 2016	CPT Codes 99211-25, 97140-59-GP, G0283-GP, 97110-GP (X2) and 97010-59-GP	$250.00	$177.67
TOTAL		$1,840.00	$1,331.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. Neither party to the dispute submitted copies of any explanation of benefits to support the denial of reimbursement for the services.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 16, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(K) states,

> Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.

The requestor submitted convincing documentation that an EOB was requested from the insurance carrier; therefore, the requestor complied with 28 Texas Administrative Code §133.307(c)(2)(K).

28 Texas Administrative Code §133.307(d)(2)(B) states,

> Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: (B) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

The respondent did not submit any EOBs or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request in accordance with 28 Texas Administrative Code §133.307(d)(2)(B). Because neither party submitted copies of the EOBs, the Division will review the disputed services per the applicable Division rules and fee guideline.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The requestor billed the following services on the disputed services:

   - A4556-Electrodes (e.g., apnea monitor), per pair.
   - 72100-Radiologic examination, spine, lumbosacral; 2 or 3 views.
   - 99203-Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
   - 97140-Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.
   - G0283-Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.
   - 97110-Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
   - 97010-Application of a modality to 1 or more areas; hot or cold packs.
   - 99211-Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
   - 99213-Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

   The requestor appended the following modifiers to disputed services:

   - GP- Services delivered under an outpatient physical therapy plan of care.
   - 59- Distinct Procedural Service.
   - 25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

   28 Texas Administrative Code §134.203(c)(1)(2) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   >
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined

by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011, which states in part, "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed services.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77375 which is located in Tomball, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

The 2016 DWC conversion factor for this service is 58.62.

The 2016 Medicare Conversion Factor is 35.8043.

On March 29, 2016, the requestor billed CPT codes A4556, 72100, 99203-25, 97140-59-GP, G0283-GP, 97110-GP, and 97010-59-GP. Based upon Medicare policies and the above formula, the Division finds:

- A4556-Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, reimbursement is not recommended.
- 72100-The Medicare participating amount is $35.39. Using the above formula the MAR is $56.12. The respondent paid $0.00. The difference between the MAR and amount paid = $56.12.
- 99203- The Medicare participating amount is $110.32. Using the above formula the MAR is $174.96. The requestor is seeking a lesser amount of $150.00. The respondent paid $0.00. The difference between the amount sought and amount paid = $150.00.
- 97140- The Medicare participating amount is $30.46. Using the above formula the MAR is $36.87. The respondent paid $0.00. The difference between the MAR and amount paid = $36.87.
- G0283- The Medicare participating amount is $14.12. Using the above formula the MAR is $16.68. The respondent paid $0.00. The difference between the MAR and amount paid = $16.68.
- 97110- The Medicare participating amount is $32.97. Using the above formula the MAR is $52.29. The respondent paid $0.00. The difference between the MAR and amount paid = $52.29.
- 97010 is a status "B" code. The Centers for Medicare & Medicaid Services (CMS) assigns a status of "B" (Bundled Code) to certain procedures on the National Physician Fee Schedule (NPFS), which is defined as, "Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no separate payment is made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident." As a result, reimbursement is not recommended.

Total recommended for this date of service is $311.96.

On March 30, 31, April 4, and 5, 2016, the requestor billed CPT codes 99211-25, 97140-59-GP, G0283-GP, 97110-GP, and 97010-59-GP. Based upon Medicare policies and the above formula, the Division finds:

- 99211- The Medicare participating amount is $20.25. Using the above formula the MAR is $32.11. The respondent paid $0.00. The difference between the MAR and amount paid = $32.11.
- 97140- The Medicare participating amount is $30.46. Using the above formula the MAR is $36.87. The respondent paid $0.00. The difference between the MAR and amount paid = $36.87.
- G0283- The Medicare participating amount is $14.12. Using the above formula the MAR is $16.68. The respondent paid $0.00. The difference between the MAR and amount paid = $16.68.
- 97110- The Medicare participating amount is $32.97. Using the above formula the MAR is $52.29. The respondent paid $0.00. The difference between the MAR and amount paid = $52.29.
- 97010 is a status "B" code; therefore, reimbursement is not recommended.

Total is $137.95 multiplied by 4 dates = $551.80.

On April 6, 2016, the requestor billed CPT codes 99213-25, 97140-59-GP, G0283-GP, 97110-GP (X2), and 97010-59-GP. Based upon Medicare policies and the above formula, the Division finds:

- 99213-The Medicare participating amount is $74.21. Using the above formula the MAR is $117.69. The requestor is seeking a lesser amount of $100.00. The respondent paid $0.00. The difference between the amount sought and paid = $100.00.
- 97140- The Medicare participating amount is $30.46. Using the above formula the MAR is $36.87. The respondent paid $0.00. The difference between the MAR and amount paid = $36.87.
- G0283- The Medicare participating amount is $14.12. Using the above formula the MAR is $16.68. The respondent paid $0.00. The difference between the MAR and amount paid = $16.68.
- 97110- The Medicare participating amount is $32.97. Using the above formula the MAR is $52.29 X 2 units = $92.01. The respondent paid $0.00. The difference between the MAR and amount paid = $92.01.
- 97010 is a status "B" code; therefore, reimbursement is not recommended.

The MAR total is $245.56. The requestor indicated on the *Table of Disputed Services* that the disputed amount for this date is $190.00; therefore, this amount is recommended.

On April 15, 2016, the requestor billed CPT code 99213-25. The Medicare participating amount is $74.21. The MAR is $117.69. The requestor is seeking a lesser amount of $100.00. The respondent paid $0.00. The difference between amount sought and paid is $100.00.

On April 25, 2016, the requestor billed CPT codes 99211-25, 97140-59-GP, G0283-GP, 97110-GP (X2) and 97010-59-GP. Based upon Medicare policies and the above formula, the Division finds:

- 99211- The Medicare participating amount is $20.25. Using the above formula the MAR is $32.11. The respondent paid $0.00. The difference between the MAR and amount paid = $32.11.
- 97140- The Medicare participating amount is $30.46. Using the above formula the MAR is $36.87. The respondent paid $0.00. The difference between the MAR and amount paid = $36.87.
- G0283- The Medicare participating amount is $14.12. Using the above formula the MAR is $16.68. The respondent paid $0.00. The difference between the MAR and amount paid = $16.68.
- 97110- The Medicare participating amount is $32.97. Using the above formula the MAR is $52.29 X 2 units = $92.01 The respondent paid $0.00. The difference between the MAR and amount paid = $92.01.
- 97010 is a status "B" code; therefore, reimbursement is not recommended.

Total is $177.67.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,331.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,331.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/19/16
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.